Maurice Hinchey NEWS

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HINCHEY TESTIFIES FOR HIGHER PAYMENTS TO AREA HOSPITALS

WASHINGTON - U.S. Representative Maurice Hinchey (NY-26) today testified at a Ways and Means subcommittee hearing to make the case for higher Medicare reimbursement rates for area hospitals. Hinchey has been working for three years to raise the rates for hospitals in the counties of Dutchess, Orange, Sullivan and Ulster.

Medicare payments, which are made to hospitals through a prospective payment system, make up a large portion of a hospital's income. The payments are adjusted to reflect the cost of buying labor and other services across areas, as measured by the wage index. To determine the wage index, data on salaries and benefits are collected from each hospital in the country. An average hospital wage is calculated for each labor market area and then compared to the national average hospital wage. Labor market areas for this purpose have the same boundaries as Metropolitan Statistical Areas (MSAs). Counties not included in MSAs are grouped into a single rural area in each state.

Averaging wages across such large and diverse geographical areas resulted in clear inequities. Recognizing this, Congress provided a "geographic adjustor", through which hospitals can apply for inclusion into a labor market area with a higher wage index. Orange County, for example, is currently included in the New York City MSA, although that status sunsets at the end of the next fiscal year. Even with the adjustor, however, some hospitals have been severely disadvantaged in attracting labor.

Today's hearing was held by the Ways and Means Subcommittee on Health to assess the geographic adjustor and to explore ways of making the system more fair. Hinchey's testimony to the subcommittee is attached.

Congressman Maurice D. Hinchey
Testimony before the Subcommittee on Health
Hearing on Medicare's Geographic Cost Adjusters
July 23, 2002

Good afternoon Chairman Johnson, Ranking Member Stark, and members of the Subcommittee. Thank you for the opportunity to address the Subcommittee today on an issue of great importance to the future of health care in my district: Medicare's Geographic Cost Adjustors.

Medicare's approach to calculating the relative wage costs among regions is, in my view, rather troubled. The administrative process by which it determines the wage index fails to consider the full range of factors that contribute to wage costs for hospitals. In the absence of an equitable, effective administrative process, many hospitals have turned to their representatives in Congress for a legislative fix. That approach is also problematic and can lead to greater disparities within localities, but it is the only avenue open to many hospitals.

For the last several years, I have been involved in an effort, both administrative and legislative, to correct an inequity in the wage reimbursement for hospitals in four counties in New York's Hudson Valley region. In many ways, I believe it is illustrative of the inherent flaws in the Medicare system, and appreciate the opportunity to share this experience with you.

The Balanced Budget Refinement Act of 1999 (BBRA) reclassified hospitals in Orange County, New York into the New York Metro Metropolitan Statistical Area (MSA) for Medicare reimbursement purposes. This provision has had what I believe to be an unintended, but negative, economic impact on six hospitals in three adjacent counties in New York's Hudson Valley region.

It is important to note that Dutchess, Orange, Sullivan and Ulster counties had, prior to the enactment of BBRA, been part of the same MSA as Orange County. Dutchess, Sullivan and Ulster counties had met the necessary criteria to be reclassified into the Newburgh, NY-PA MSA (Newburgh is located in Orange County). Based on the Health Care Financing Administration's (HCFA) decision to reclassify them, it in effect acknowledged that the hospitals operate within a similar wage index to hospitals in Orange County and should be treated similarly.

When the Orange County reclassification was under consideration as part of BBRA, my colleagues and I from the Hudson Valley did not oppose the change. At the time, our staff members had been led by representatives of HCFA to believe that the Dutchess, Sullivan and Ulster county hospitals would automatically be reclassified into the New York Metro MSA along with the Orange County hospitals because of their status as part of the Newburgh MSA. We received assurances from HCFA that the legislative fix, which moved the Orange County hospitals into the New York Metro MSA, would correspondingly move the other hospitals into the New York Metro MSA. However, when the other Hudson Valley hospitals pursued the reclassification after BBRA was enacted, HCFA ruled that only those hospitals geographically located in Orange County could receive the New York Metro wage index.

Having failed to correct this imbalance through the administrative appeals process, I have sponsored several efforts on behalf of the hospitals to secure a legislative fix. I understand that this is not the Committee's preferred mechanism for addressing wage reclassifications, but the six hospitals in Dutchess, Sullivan and Ulster counties had no other recourse available to them.

Needless to say, the Orange County legislative fix has placed the six hospitals in the adjoining counties of Dutchess, Sullivan and Ulster at a severe competitive disadvantage. While the hospitals in all four Hudson Valley counties are competing for staff with the rest of the New York Metro MSA, they also compete most directly against each other.

The reclassification of the Orange County hospitals into the New York Metro MSA has resulted in a significant increase in Medicare reimbursement for wage-related costs for those hospitals. As a result of this provision, Orange County hospitals have gained $8 - $10 million annually in enhanced reimbursement. This enables the Orange County hospitals to offer much more generous compensation to their employees and to lure staff away from other hospitals.

This ability to pay higher wages has been critical. Our local hospitals, like most across the country, are facing profound shortages in the health care workforce. Competition for registered nurses, technicians and certified aides has been fierce but ultimately the hospitals that can pay the highest wages, provide the most generous fringe benefits and even pay hiring bonuses are winning the battle.

Having worked with the Hudson Valley hospitals on this issue since 1999, I have experienced firsthand the problems that are inherent in the manner in which wage reclassifications are currently handled. I hope that as the Committee prepares to make changes to the system, you will take several concerns into consideration.

First, the data set considered by Medicare in determining geographic cost adjustors is not broad enough to provide a true representation of wage costs. My understanding is that the only data considered by Medicare in making these determinations are the salaries and benefits offered at other hospitals. This does not consider the many other contributing factors to wage costs.

In particular, Medicare does not take into consideration the fluidity of today's labor markets. In the case of the hospitals from my district, it is critically important to take into account that workers are prepared to travel well beyond the towns or counties in which they live to find lucrative work. New York's Hudson Valley region is sandwiched between the New York City metropolitan area and the Albany metropolitan area. Workers that live in the Hudson Valley are accustomed to commuting to either of these metropolitan areas for work. Therefore, when a substantially higher rate of pay is available in Albany or New York, workers will leave the Hudson Valley for those jobs. Because of the BBRA language that reclassified the Orange County hospitals, workers in Dutchess, Sullivan and Ulster counties need only to travel to Orange County to receive wages that can be as much as 40 or 50 percent higher. This severely compromises the ability of hospitals in the lower-paying counties to retain staff and, ultimately, stay in business.

A broader consideration of wage costs is used elsewhere by the federal government and perhaps could be considered for Medicare wage rates. When the Office of Personnel Management determines locality pay for federal workers, it not only includes the salary levels for comparable jobs in the private sector, it also assesses the local cost of living, commuting rates and other factors. I take the liberty of suggesting to the Subcommittee that a similar wage survey could be taken into consideration for Medicare.

Because the administrative process does not currently include adequate mechanisms for assessing wage costs, hospitals may have no other remedy at their disposal except for a legislative correction. As the representative for many of the hospitals that have been endangered by the Orange County reclassification, I have been more than happy to work on their behalf for such a correction.

However, I realize that there are inherent dangers in pursuing legislative corrections. Taking a "rifle shot" approach to wage reclassifications does not necessarily make for a fair and equitable system. In the case of the hospitals I represent, the Orange County reclassification plucked one group of hospitals out of an MSA and moved it into a higher paying MSA, despite the fact that HCFA's administrative process had already determined that Orange County shared a similar wage index with hospitals in Dutchess, Sullivan and Ulster counties. Although Medicare should not be in the position of giving unfair advantages to some hospitals over others, making political changes to the wage index certainly increases the likelihood that that will happen. Legislative reclassifications of hospitals can directly impact other hospitals in their immediate vicinity, but that is not necessarily part of the decision-making process.

The present system has flaws that need to be addressed. Although I understand that it is a very complex and difficult task, I hope that the Subcommittee will consider serious reforms to Medicare's wage indexing structure. I look forward to working with you to supply any details that the committee may need regarding the situation I have presented today.

Thank you.